15-0900-16029-2

STATE OF MINNESOTA
OFFICE OF ADMINISTRATIVE HEARINGS
FOR THE COMMISSIONER OF HEALTH

In the Matter of Golden Crest Healthcare Center Survey Completed 4/23/2004

RECOMMENDED DECISION

The above matter was the subject of an informal dispute resolution meeting conducted by Administrative Law Judge Beverly Jones Heydinger on Thursday, September 9, 2004, at 9:30 a.m. at the Office of Administrative Hearings, 100 Washington Avenue South, Suite 1700, Minneapolis, MN 55401. The meeting concluded on that date.

Appearances: Marci Martinson and Mary Cahill, Division of Facility and Provider Compliance, Department of Health, 1645 Energy Drive, Suite 300, St. Paul, MN 55108-2970. Shane P. Roche and Peggy Fossum, Golden Crest Healthcare Center, 2413 First Avenue, Hibbing, MN 55746.

NOTICE

Under Minn. Stat. § 144A.10, subd. 16(d)(6) this recommended decision is not binding on the Commissioner of Health. Under Department of Health Information Bulletin 04-07, the Commissioner must mail a final decision to the facility indicating whether or not the Commissioner accepts or rejects the recommended decision of the Administrative Law Judge within 10 calendar days of receipt of this recommended decision.

Based upon the exhibits submitted and the arguments made and for the reasons set out in the Memorandum which follows, the Administrative Law Judge makes the following:

RECOMMENDED DECISION

1. That citation F-274 is supported in full;

2. That citation F-309 be dismissed.

Dated this 17th day of September, 2004.

S/ Beverly Jones Heydinger
BEVERLY JONES HEYDINGER
Administrative Law Judge

Recorded: Tape-recorded
(One Tape, No Transcript Prepared)

MEMORANDUM

Citation F-274 – Failure to Assess Change in Status.

A facility is required to conduct an assessment of the resident on a regular schedule and also when there is a significant change in the resident's status in two or more areas. The Department determined that Golden Crest did not conduct a Significant Change In Status Assessment (SCSA) for Resident #4. On December 17, 2003, Resident #4 completed physical therapy (PT) because she had reached her maximum functional potential. On March 25, 2004, Resident #4 completed occupational therapy (OT) because she had met her goals.[1] The Department concluded that the end of PT and OT should have triggered an SCSA because their completion signaled a change in two areas, ambulation and activities of daily living. It believed that reassessment was needed to determine if changes should be made to the Resident's care plan to assure appropriate care.

The Facility did not consider conducting an SCSA when the therapy ended.

The MDS v2.0 User's Manual, defines a "significant change" as a decline or improvement in a resident's status that will not resolve itself without staff intervention, impacts more than one area of the resident's health status and requires interdisciplinary review and/or revision of the care plan. (Facility Ex. F-274, Ex. A, page 2-7).

The Facility contends that an SCSA was not appropriate. Although it does not dispute that Resident #4 had completed PT and OT and had made steady progress, the Facility contended that Resident #4's condition had not stabilized and could be affected by a change in medication occurring at the same time. The Resident was being carefully monitored to determine the effect of the medication change on her activities of daily living (See Dept. Ex. H-4). However, the Resident Review worksheet reflects that the resident's functioning on April 23, 2004 was higher than the level reflected in her prior assessment (Dept. Ex. J-26). Without an assessment it is not clear if the plan of care was still appropriate. The Facility asserted that the care plan addressed the activities of daily living and ambulation, but the care plan was not provided.

Under the circumstances, the citation should stand. There is no documentation that the Facility recognized a significant improvement affecting activities of daily living and ambulation and either reviewed the care plan to assure it met the resident's current needs, or documented that an SCSA would

[1] Initially the Department also relied on unplanned weight loss as another indicator that an SCSA was needed. It has dropped that basis.

be delayed for a specific time to allow evaluation of the Resident's medication change.

Citation F-309 – Highest Level of Physical Functioning

A facility must ensure that a resident obtains optimal improvement or does not deteriorate within the limits of recognized pathology and the normal aging process. Resident #5 had red, inflamed areas around his scrotum on April 20, 2004, and was not checked for incontinence within the 2 hours set forth in his care plan. The Department surveyor observed that the perineal care was done improperly. The citation was based on the surveyor's conclusion that the Facility conducted an inadequate assessment of the resident's past history of skin conditions, failed to develop a care plan, failed to implement the resident's incontinence plan, and improperly cared for the affected areas. It contends that this led to actual harm because the resident developed red, irritated skin with open areas. (Dept. Ex. D.)

The Facility denies that the resident's history demonstrated skin breakdown. It showed that his skin condition was monitored regularly. (Facility Exs. B and D). Exhibit D shows that the resident's skin condition was checked weekly from February through April 17, 2004 and that the skin was intact, including on the buttocks and perineal area. In addition, because the resident was incontinent and could not request or respond to bowel or bladder cues, his plan of care required checking every two hours.

The redness and open areas were first observed three days later on April 20, 2004. The Facility's immediate response was inadequate. The area was cleaned improperly and no cream was applied. In addition, the resident was not checked every two hours as required by the plan of care (Dept. Ex. E-30). The condition was worse the next day.

However, this citation was not for improper continence care (a separate violation, not challenged). This citation was for the facility's failure to provide the necessary care and services to attain the highest practicable physical, mental and psychosocial well-being in accordance with the comprehensive assessment and plan of care. The Department failed to show that the resident was either improperly assessed or had an improper plan of care that led to the redness and sores. Rather, the Facility failed to implement the care plan and follow established skin care procedures. On the same day that skin problems were identified, April 20, 2004, the facility notified the resident's doctor, a physician's assistant checked the patient soon after, and the care plan was amended.

B.J.H.